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Home Office

Minutes

Title of meeting	Pathology Delivery Board		
Date	9th November 2017	**Time**	11:00hrs
Venue	Conference Room 3b, 2 Marsham Street, London, SW1P 4DF		
Chair	Mr Alan Pratt	**Secretary**	Mr Dean Jones
		Copies to	Ms Sonya Baylis

Attendees

Dr Jeff Adams (JA)	Forensic Science Regulation Unit, Home Office
Mr Martin Allix (MA)	Forensic Pathology Officer, Home Office
Ms Sonya Baylis (SBa)	National Crime Agency
Mr Mark Bishop (MBi)	Operational Policy, Crown Prosecution Service
Mr Duncan Brown (DB)	Representing Jo Taylor, College of Policing
Mr Martin Bottomley (MB)	National Police Homicide Working Group
Dr Nathaniel Cary (NC)	Chair of the Forensic Pathology Specialist Advisory Committee, Royal College of Pathologists
Dr Naomi Carter (NCr)	President of the British Association in Forensic Medicine
Mr Nick Casey (NiC)	Representing the National Crime Agency
Prof Jack Crane (JC)	The Board's former Independent Responsible Officer
Dr Russell Delaney (RD)	Forensic Pathologist, Group Practice representative
DI Gavin Dudfield (GD)	Representing Chief Constable Simpson, Dorset Police
Mr John Foster (JF)	Operational Forensic Consultant, Metropolitan Police Service
Mr Mark Greenhorn (MG)	Head of Science Secretariat, Pathology, Regulation and Services Unit, Home Office
Ms Brenda Jones (BJ)	Representing the Chief Coroner's Office
Mr Dean Jones (DJ)	Forensic Pathology Manager, Home Office
Prof Guy Rutty (GR)	The Board's Independent Responsible Officer
Mrs Rachel Webb (RW)	Minute-taker, Forensic Pathology Unit (FPU), Home Office
Dr Fiona Wilcox (FW)	H.M Senior Coroner for London (Inner West), representing the Coroners' Society of England and Wales

Apologies

Caroline Browne (CB)	Head of Regulation, Human Tissue Authority
Mr Glenn Palmer (GP)	Head of Coroners, Burials, Cremations & Enquiries, MOJ
CC Debbie Simpson (DS)	National Police Lead on Forensic Pathology
Ms Jo Taylor (JT)	Representing the College of Policing

1. **Welcome and Apologies**

1.1 The chair opened the meeting by thanking those present for attending. Members were asked to introduce themselves for the benefit of new members. The apologies above were noted.

1.2 The chair took the opportunity to offer sincere thanks to Dr Nathaniel Cary for his time on the board representing the Royal College of Pathologists, Forensic Pathology Specialty Advisory Committee. Dr Nat Cary's term of office comes to an end on 16th November after the College's AGM.

2. **Minutes from the meeting on 1st November 2016**

2.1 The minutes of the last meeting received comments and were agreed in correspondence. A briefing note was circulated in lieu of the cancelled meeting in May and was attached to the papers for reference.

2.2 **Actions from the previous meeting**

2.2.1 The following actions were marked as completed: PDB01/11/2016 2.11; 3.5.2; 3.6.9; 3.7.3; 3.8.8; 3.8.9; 3.10.3; 7.3; 8.10; 10.7.

2.2.2 In relation to PDB01/11/2016 12.3.6 – Secure email – The FPU felt that the method of transfer of information and files between the pathologist, coroner and police was a matter of agreement between the parties concerned and other than providing advice; this is not a matter that the PDB can impose upon members of the register.

2.2.3 RD stated that since the system updates of the CJSM network, the service was better. The issues from a year ago were less problematic. DJ therefore took on an action.

2.2.4 **ACTION:** FPU to send out a fresh invitation for those on the Home Office Register of Forensic Pathologists to sign up to secure email system such as CJSM.

2.2.5 Members of the board discussed their agreement that data security was a matter between the pathologist, police and coroner but that the board had a duty to make members of the register aware of their own data security responsibilities.

2.2.6 **ACTION:** Look at options such as Resilience Direct and CSJM and write a note to members of the register that highlights data security and encourages sensible measures.

2.3 **Hutton Review Recommendations**

2.3.1 Members of the board discussed the recommendations, noting the ministerial statement in answer to the parliamentary question [67380] asked by Dr Sarah Wollaston: http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-03-09/67380

2.3.2 The chair stated that the board had done all that it could in relation to the Hutton recommendations, apart from the main recommendation of a National Autopsy Service It is now out of its control and the actions should be closed.

3. **Standing Items – Updates from:**

3.1 **Complaints**

3.1.1 The board was content with the way in which complaints were handled by the board's secretariat.

3.2 **The Royal College of Pathologists (RCPath)**

3.2.1 Following Dr Cary retiring as chair of the Forensic Pathology Specialty Advisory Committee, Dr Sacha Kolar will be the next chair and has been invited to the next PDB.

3.2.2 The RCPath now has a Death Investigation Group which covers the interface between forensic and other forms of sudden death investigation and Dr Cary hopes to remain part of the group.

3.2.3 Dr Cary met with the Chief Coroner and President of RCPath where there was some discussion about 2nd post-mortem examinations and the need for them to happen. The Chief Coroner and others are considering this matter and further discussions will take place

3.2.4 A discussion ensued about the value of cross-sectional scanning in forensic cases and it was highlighted that it is good practice in all relevant cases, however JF questioned the cost of doing so and the subject of specialist autopsy centres arose. JF had written a paper on this subject some years ago and agreed to refresh the report. He will later review whether it is possible to commence a project in implement the recommendations within that report.

3.2.5 **ACTION:** Analyse what options are available regarding the setting up of a London based trauma centre for PM's and with Scanning facilities. JF to refresh his previous paper regarding regional PM centres

3.3 **Group Practices**

3.3.1 No issues to report.

3.4 **The Forensic Science Regulator's Forensic Pathology Specialist Group (FPSG)**

3.4.1 JA said that there had been a number of amendments to the Code of Practice and Performance Standards for Forensic Pathology which will be discussed at the Regulator's FPSG meeting that afternoon.

3.4.2 The 2016 Audit Report is about to be published and the Forensic Science Regulator's office will be initiating the audit for this year very shortly.

3.4.3 Forensic Science Regulator has done some work with the Royal College of Pathologists, Forensic Pathology Specialty Advisory Committee and BAFM in relation with the use of 'excited delirium' as a term in relation to cause of death. It was noted that this issue featured in the report into deaths in custody by Dame Elish Angiolini.

3.4.4 The Regulator is also putting forward guidance on reports and statements this afternoon (at the FPSG meeting) and there are quite a few changes to the Criminal Procedure Rules and Criminal Practice Directions in Experts Report. The Regulator has produced general guidance and will be bringing it to the meeting to see whether it needs adjusting for forensic pathologists.

3.5 **National Policing Homicide Working Group (HWG)**

3.5.1 Members of the board discussed the continuing referral to police forces of forensic cases that had originally been scheduled for a routine post-mortem examination. There had not been a decline in cases and the average number of cases referred was around 20 cases per calendar quarter.

3.6 **Forensic Pathology Management Information**

3.6.1 The MI data reports were distributed to members before the meeting. Members were interested to know whether there was a correlation between the number of cases originally referred for a routine post-mortem examination but then referred for a forensic post-mortem examination and the percentage of homicide in that police force.

3.6.2 **ACTION:** FPU to engage with the stats team to look into figures.

3.7 **Appraisal and Revalidation**

3.7.1 GR reported on his work as the board's independent responsible officer since his appointment in April. There were a number of statutory requirements for the RO in acting on behalf of the Pathology Delivery Board which is the Designated Body as defined by the Medical Profession (Responsible Officers) (Amendment) Regulations 2013 for all members of the Home Office Register of Forensic Pathologists. GR has been working his way through those requirements and bringing himself up to speed with training for the role.

3.7.2 GR and the FPU had met in July and a number of actions were being taken forward:

- Training of Dr Stuart Hamilton who is now a forensic pathology appraiser.
- GR will be producing a report for the designated body which is an annual requirement.
- FPU writing SOP in order to formalise the processes for registration of members to the register, and disciplinary matters.
- Reorganisation of relationship with complaint handling between the Home Office and the RO.
- Future development of the appraisal system.
- Appointment of Dr Nathaniel Cary as clinical lead appraiser on a voluntary basis.
- Redevelopment of appraisal audit process.
- Organisation of appraiser training for February 2018

3.7.3 GR wished to thank the FPU for its support and hard work since his appointment.

3.8 **Training**

3.8.1 MA produced a paper detailing the different courses that he had organised for pathologists. Since the last meeting of the PDB, the FPU has been involved in delivering or facilitating training in the following areas:

3.8.2 Organ Specific Forensic Pathology

- The unit's involvement in sponsoring and facilitating criminal justice training courses for organ specific pathologists continues. A one week course for neuro pathologists took place at College of Policing, Harperley Hall in July of this year. It was run in collaboration with senior consultants from the world of forensic

neuropathology and consisted of a series of lectures from leading experts in the field of forensic neuropathology and associated disciplines; plus talks from lawyers, a Senior Coroner and a police Senior Investigating Officer. Delegates also took part in a practical court room training exercise. Ten delegates attended and feedback at the end of the course was extremely positive. Several delegates expressed an interest in undertaking further training in the field, with a view to taking on CJS related cases in the future.

- A similar course for paediatric pathologists is being planned for July 2018.

3.8.3 Coroner's Officer Training

- The national program to train all new and existing coroners' officers in the law, regulations and procedures applicable to their role is still underway.
- A representative from the FPU provides an input to every course on the role of the unit, to include discussions on the subject of the potential for missed homicides, based on case studies taken from research conducted by the HOFPU. The police 'Practice Advice in Dealing with Sudden and Unexpected Death and the Medical Investigation' are used by the Judicial College as a core training document for the 2017 round of training.

3.8.4 SIO Training

- The College of Policing has recently re-established the national SIO development course at College of Policing, Ryton, following a period of suspension of delivery whilst the course was being re-written.
- A representative from the HOFPU provides an input to every course on the role of the unit; police procedures on human tissue seizure retention and disposal and other associated matters and actions at the initial scene of sudden and unexpected death. This is an ongoing commitment. Delivery is based upon the police 'Practice Advice in Dealing with Sudden and Unexpected Death and the Medical Investigation'.
- Feedback from both courses has been very positive. The next SIO course we are delivering on will be 6th December.

3.8.5 Forensic Pathology CPD Study Day

- A report (paper 4.1) on the recent forensic pathology study day held at the College of Policing, Ryton, has been circulated for discussion under agenda item 4.1
- The FPU has now sponsored and facilitated two such events and will continue to do so, on an annual basis.
- The main purpose of these events is to provide a forum for members of the profession to come together to discuss topical items and present case studies relevant to the forensic pathology community; to assist with annual CPD requirements and to facilitate the sharing of learning amongst the profession.
- Although the events are primarily for members of the Home Office Register, they are also open to all forensic pathologists in Scotland and Northern Ireland.

3.8.6 Crime Scene Managers Course

- The FPU's involvement in the CSM course has ceased due to withdrawal of forensic training by the College of Policing. This will cease our arrangement with the College to provide facilities at Harperley Hall to run the Pathology CJS course.

- It is hoped that FPU can negotiate with the College to continue current arrangements whereby the College provide facilities for the annual Pathology CJS course in return for FPU services on the SIO course.

3.8.7 NC wished to thank the Home Office Forensic Pathology Unit for organising the organ specific training which is equipping more organ specific pathologists to become involved in death investigation.

3.9 **Home Office Register of Forensic Pathologists ('the register')**

3.9.1 The Register is available at: https://www.gov.uk/government/publications/home-office-register-of-forensic-pathologists-february-2013/home-office-register-of-forensic-pathologists.

3.9.2 Since the last meeting there had been the following movement in respect of registrants: retirement of Dr Dick Shepherd on 3rd April 2017; and the additions of Dr Matthew Lyall on 1st June and Dr Virginia Fitzpatrick-Swallow on 9th June 2017.

3.10 **Forensic Pathology Trainees Update**

3.10.1 MA provided board members with a list of those doctors currently in forensic pathology training posts in Liverpool and Newcastle.

3.10.2 Leicester is looking to recruit 2 forensic pathology trainees shortly with a start date of April – May 2018.

3.10.3 Dr Mulcahy is due to apply for registration on to the Home Office Register of Forensic Pathologists in the next 2 months and anticipates taking up a part-time position in Newcastle.

3.10.4 **ACTION:** The chair questioned whether the paper submitted on succession planning (PDB01112016 3.10.3) adequately addressed the issues. DJ to seek clarification with the chair.

3.11 **2018/19 Forensic Case Fee Uplift**

3.11.1 As the board would not be sitting until after the next financial year begins, MA wished to notify the board that the Home Office would start opening the lines of negotiation between the NPCC and the BAFM for the 2018-19 forensic post-mortem case fee. The fee is negotiated in line with the public sector average pay award.

3.11.2 The current fee is £2565 for cases where police retain human tissue in licensed police facilities, and £2586 where forensic pathologists pay for human tissue to be retained in licensed forensic facilities.

3.11.3 Members discussed the coronial case fee which has remained unchanged for the past 20 years at £96.80; and the difference between the forensic case fee and the coronial case fee with the latter being set in regulation. Although the mechanism of bringing the coronial case fee in line with current market demands, this is a matter for the Ministry of Justice.

4. **Forensic Pathology CPD Study Day – Lessons Learned**

4.1 There was a paper circulated for members of the board. The CPD day was dedicated to mass fatality, Disaster Victim Identification (DVI) and terrorist type incidents.

4.2 MG wanted to share some of the key learning points from the day in order to open the dialogue around the table. MG attended the study day; the first pathology related event that he had attended in his role as unit overseer. He was very impressed with the presentations at the event and is keen to fund future events and ensure that it is documented for the board and wider forensic community.

4.3 Members of the board who were present at the CPD meeting wished to thank MA for arranging the study day.

4.4 It was felt that it would be worthwhile to continue with the annual study day going forward. The next CPD day will be October / November 2018.

4.5 **ACTION:** MA to speak to UK DVI about who could arrange a multi-discipline study day / lessons learned debrief in relation to recent terrorist / disaster incidents.

5. **Police Practice Advice. Dealing with Sudden and Unexpected Death**

5.1 DJ thanked Duncan Brown for attending in relation to this matter. The document (formerly chapter 11 of the Murder Investigation Manual) has been approved by the current and former Chief Coroner. It has gone through a detailed process of review with different stakeholders, including the Coroners' Society, Homicide Working Group (NPCC) and the BAFM. It has been through a Solutions Panel at the College of Policing. There is a sister document to this which is a simple Standard Operating Procedure flowchart and has been badged with the College of Policing.

5.2 Then board was seeking assurance that the necessary procedures to publicise the Practice Advice and Standard Operating Procedure were being taken forward, alongside a review of the training arrangements for new police joiners and supervisors.

5.3 DB confirmed that the Practice Advice is available on the Police Online Learning & Knowledge Area (POLKA) and highlighted expected workflow and timescales moving forward. It is also available on the Home Office Forensic Pathology web page at https://www.gov.uk/government/publications/sudden-unexpected-death-medical-investigation

5.4 The flowchart is being incorporated into the syllabus for the police constable degree apprenticeship as part of the supporting information. In terms of the police learning programme, it will be incorporated and uploaded onto the College of Policing Managed Learning Environment or POLKA depending on its status, it will also be incorporated into the standard policing curriculum update and training departments will be made aware of that.

5.5 **ACTION:** DB to report back to the PDB when the significant milestones on getting the practice advice out to forces, has been reached.

6. **Review of Suitability Rules 'the rules'**

6.1 DJ asked for this item to be delayed until the next meeting following discussions with the board's independent responsible officer (BIRO).

6.2 DJ recounted some problems the unit had faced when dealing with minor complaints received into the Home Office that, on following the Suitability Rules process, had to be referred to the Disciplinary Review Panel, which instead could have been referred back to the group practice for internal resolution. The team had therefore set about updating the rules to facilitate that change of process.

6.3 During the team's work with the BIRO, he highlighted that although there are 2 processes: that of the Home Office, to protect the criminal justice system and that of the Responsible Officer and the GMC to protect patient safety, it would be necessary for the RO to investigate every complaint. Amending the Suitability Rules to accommodate these 2 investigative processes and the ROs statutory requirement to investigate all complaints, will streamline the process.

6.4 One member asked how different complaints would be handled, for example, a complaint against Prof Rutty in his role as a Home Office registered forensic pathologist will go to his RO, The Chief Medical Officer, or a conflict of interest between Prof Rutty and a member of the designated body or Register, will go to the Chief Medical Officer or another senior RO for investigation and resolution. GR confirmed that there is a well defined process for handling such complaints and conflicts of interest.

6.5 The board agreed that consolidation was a good idea and supported the approach taken by the FPU.

7. **HTA Inspection of University of Wales Mortuary in Cardiff**

7.1 The board was expecting a press release the previous day concerning the Human Tissue Authority inspection of Cardiff mortuary which received an adverse report especially in relation to handling police human tissue. This matter is subject to a Gold Group resolution process in which DJ is a part and therefore no further details can at this stage be released.

7.2 **ACTION:** Once the report has been published this will be disseminated to the members of the board.

8. **Histopathologist Refusal to Conduct Routine Post-Mortem Examination**

8.1 JF wished to bring up a trend that he believed might be countrywide of a histopathologist refusing to carry out a routine post-mortem examination when all evidence points to a natural death even if the example given was caused by an accident. Such cases result in the coroner asking for a forensic PM at great expense to the police. JF felt that there were an increasing number of such cases in the Met.

8.2 Members of the board discussed different scenarios with many agreeing that the histopathologist acts as the gatekeeper in these sorts of cases. One member highlighted how the Royal College of Pathologist's guidelines are clear in that if an individual pathologist has a concern about a case they should bring it to the attention of the coroner and they should not be put under any pressure to continue with the case.

8.3 **ACTION:** DJ and JF to look further into the available stats to see if this was an increasing trend which can form the evidence base on which to take forward any further action.

9. **Bishop James Jones' Hillsborough Report**

9.1 The Hillsborough report produced by The Right Reverend James Jones, Bishop of Liverpool, was published on 1st November.

9.2 DJ wished to bring to the board's attention the 2 learning points, 15 and 17, which fall within the remit of the board.

9.3 Learning point 17 asks for the Government to formally respond to the Hutton Review of Forensic Pathology Services in England and Wales, however the board agreed that the answer to parliamentary question 67380 provided by the Right Honourable Brandon Lewis on 15th March 2017 was a formal response.

9.4 Learning point 15 addresses pathology failures at first inquest and the board has been asked to review forensic pathology on the basis that if the Hillsborough tragedy were to take place today would the failures happen again?

9.5 JC stated that the bishop had asked for his input into the inquiry. This report was essentially from the perspective of the relatives who had expressed concerns that potential shortfalls in the autopsy findings should not be repeated in the event of future disasters, and that lessons have been learnt.

9.6 Members were confident that things had improved quite significantly. There had been 3 forensic pathology reviews since the Hillsborough tragedy, the Code of Practice and Performance Standards for Forensic Pathology had been written and there was now a recognised Home Office Register of Forensic Pathologists.

9.7 Next week a multi-departmental meeting will take place, where responses to the Hillsborough report will be discussed in order to form a Government response.

9.8 At this point the PDB will be able to ascertain what learning points the board will take forward.

9.9 **ACTION:** PDB members to review the Hillsborough report and respond to DJ with their thoughts and comments in order to feed this information to the multi-departmental meeting next week which seeks to inform a Government response to the report.

9.10 Members went on to discuss the progress of the NPCC UK DVI Unit which arranged national mass fatality training exercises for all services to train their members in such incidents. GR thought it would be good if every forensic pathology group practice had experience in this training.

9.11 **ACTION:** FPU Contact UK DVI to ask for an invitation for all pathologists to attend the future DVI exercises and training events.

10. **AOB**

10.1 **UK Body Farm Update**

10.1.2 The HTA submitted a written update as follows:

10.1.3 Huddersfield University is continuing its work to establish a Human Taphonomy Centre in the UK. It is generally agreed that taphonomy falls outside the Human Tissue Act 2004 (HT Act) and so would not be licensed by the Human Tissue Authority (the HTA). Similarly, there would be no requirement under the HT Act for consent to be given for the use of a body for taphonomy.

10.1.4 The HTA understands that there is unlikely to be any legislation in the immediate future which would bring taphonomy within the scope of the HT Act. Any involvement from the HTA would, therefore, have to be within its current remit. Further work is now being taken forward to explore the risks arising in consent, traceability and storage, and whether regulation could mitigate these risks. This work will include how such facilities are regulated elsewhere and whether there is existing legislation in place which might mitigate against those risks.

10.1.5 The HTA will keep the Pathology Delivery Board up to date with its progress.

10.2 **Forensic Pathologists as Experts in Coroner's Court**

10.2.1 NCr had written to the Chief Coroner to voice her concerns about the lack of recognition by coroner's courts of forensic pathologists giving expert evidence of opinion, such as they give in crown court. The coroner's courts do not operate in the same way as the crown court. The fees for expert witnesses in the coroner's courts are set out in The Coroner Allowances, Fees and Expense Regulations 2013.
http://www.legislation.gov.uk/uksi/2013/1615/contents/made

10.2.2 The decision as to whether a pathologist appearing in a coroner's court will be paid as the expert witness fee is the judicial decision of the coroner. BJ explained that any changes to these regulations was a matter for government and not for the Chief Coroner who is a member of the Judiciary.

10.2.3 **ACTION:** Re-circulate letter from the Chief Coroner which highlights the different court fee structures.

10.3 **Recommendations by pathologists/CPS for certain medical experts**

10.3.1 NiC gave a brief explanation of the role of the National Injuries Database and the availability of medical experts and in particular the importance of ensuring that the Forensic Pathologist in the case are kept fully aware of other medical professionals used in an investigation to avoid a conflict.

11 **Future PDB Meetings**

11.1 Wednesday 9th May 2018 – Conference Room 11, at 12noon, Home Office HQ.

11.2 Wednesday 7th November 2018 – Conference Room 3b at 11am, Home Office HQ.

There being no further business the meeting was closed at 1.35pm.